D H E C

PROMOTE PROTECT PROSPER

SC ADAP CENTRAL PHARMACY UPDATE

Please fill out and return to:
Central Pharmacy SP-16
PO Box 809
State Park, SC 29147-0809

Phone Numbers:
(803) 896-6250
(800) 856-9954

FAILURE TO RETURN THIS INFORMATION COULD RESULT IN A DELAY IN FILLING YOUR PRESCRIPTIONS

Patient Information: (Please Print)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon ____ Day ____ Year ____ Sex: ____ Weight: ____ Social Security #: ____/____/____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other _____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Annual** Gross Income
Your Information					

Current Physician: _____ **Current Case Manager:** _____

CURRENT MEDICATIONS:

_____ _____ _____ _____

Are you allergic to or have reactions to any medicines? _____ If yes, which medicines? _____

Are you allergic to or have reactions to any foods? _____ If yes, which foods? _____

Please note: Funds for this program come from Federal programs and are for low-income persons. This program should be the payor of last resort. Persons with Medicaid coverage or Veteran's Affairs Benefits cannot qualify for this program. Persons with insurance coverage may qualify for reimbursement of copay/deductible charges.

Are you currently approved for Medicaid or Medicaid Waiver benefits? **Yes** ____ **No** ____
Do you currently have an application pending for Medicaid or Medicaid Waiver benefits? **Yes** ____ **No** ____
Do you have insurance coverage for prescriptions? **Yes** ____ **No** ____

If yes, Company Name _____ Policy Number _____ % of Coverage _____

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the current physician and current case manager indicated above.***

Signature of Patient _____ **Date** _____

Central Pharmacy
P. O. Box 809
State Park, SC 29147
803-896-6250 – Columbia
800-856-9954 – Toll Free

Dear Sir or Madam:

Please complete and return immediately to Central Pharmacy in the Business Reply envelope provided. No Stamp is needed. It can be placed in any mailbox.

The **Social and Financial Data** is important and must be completed or the form will be returned to you for completion. Please tell us where you receive the money that you live on and also tell us if the amount that you put down is a weekly, monthly, or yearly amount. **If your income is zero, please put zero in the amount box. Do Not Leave this Box Blank!!!** Please list all of your dependents in this section because **this information may be useful in helping you to continue to qualify for this program.**

You are required to fill out this form once a year in order to stay active on this program and continue to receive your medications. **Please fill it out when you get it and mail it back to us as soon as possible.**

If we do not have a current Update form for you there may be a delay in receiving medications or you may be removed from the program. We want you to stay healthy so **please call us if you have problems with this form or contact your case manager.**
If you have any questions, please call us at **1-800-856-9954 or in Columbia at 896-6250.**

Sincerely,

Melissa Villnow, Director
Don Ray, R. Ph.
Jim Pangle, R. Ph.
Monette Sox, R. Ph.
Missie Fowler, Pharm Tech
Laura Berry, ADAP Enrollment